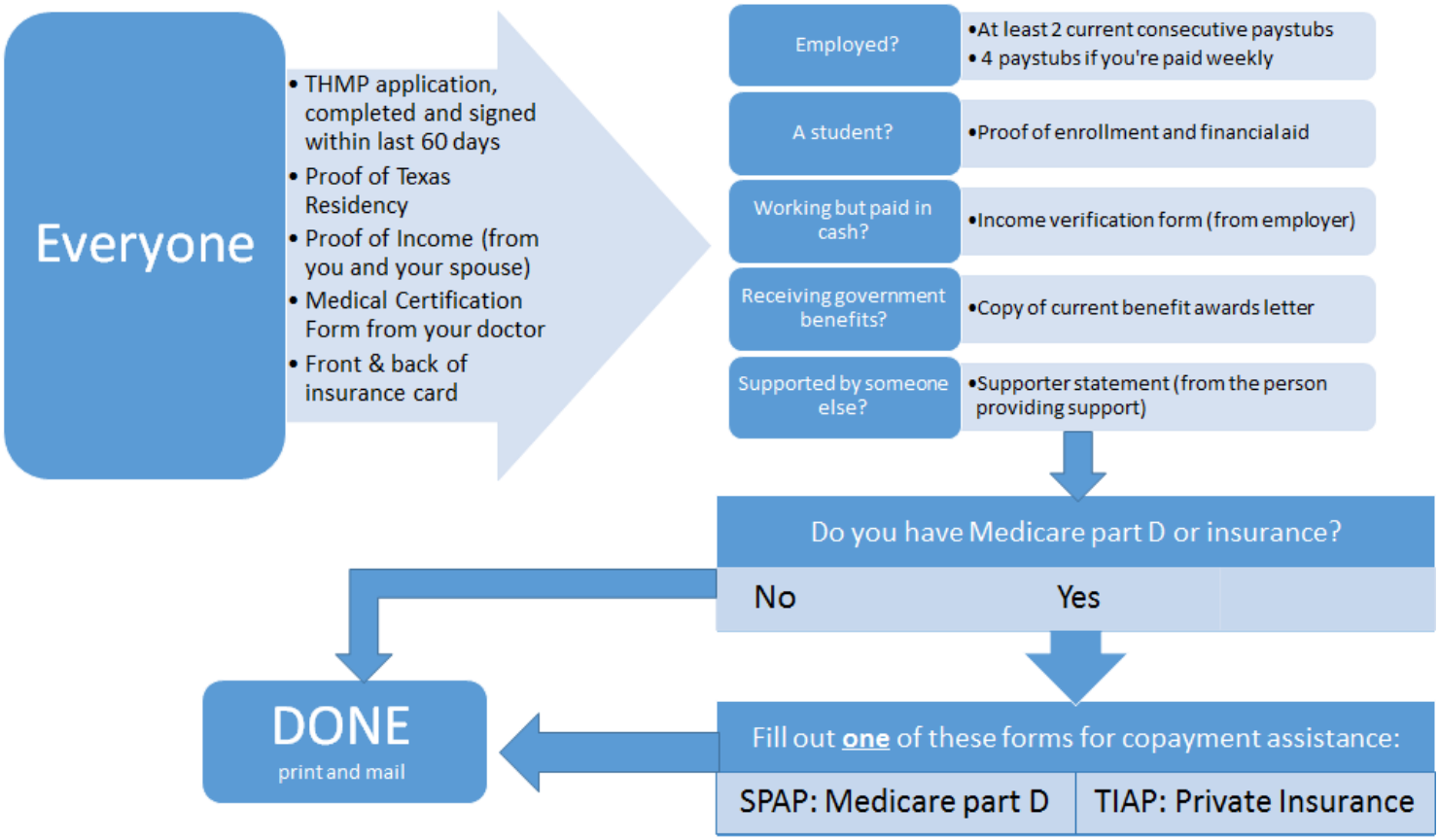
APPLICATION FOR MEDICATION ASSISTANCE

Texas Department of State Health Services
ATTN: MSJA - MC 1873
PO Box 149347, Austin, TX 78714-9347
1-800-255-1090

- **Mail the completed application and copies of supporting documentation to the address listed above**
- **Do not send original documents**, they will not be returned
- For help with this application call **1-800-255-1090** or visit www.dshs.state.tx.us/hivstd/meds

Is your application complete?



PRIVACY NOTIFICATION

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See www.dshs.state.tx.us for more information on privacy notification. (Reference: Texas Government Code, Sections 522.021, 522.023, 559.003 and 559.004)

For additional information, including a review of Frequently Asked Questions and downloadable copies of program documents, please visit the THMP web site at www.dshs.state.tx.us/hivstd/meds.

For additional information on AIDS service organizations, case management services and community resources in your local area, please call 2-1-1. If you have any questions, comments or concerns regarding the Texas HIV Medication Program and this application for assistance, please call the program directly at 1-800-255-1090.

PERSONAL INFORMATION

1. Last Name	First Name	Middle Name	Suffix (Jr., Sr., III)

2. Previous names (including maiden name, aliases, and name changes)

3. Do you have a SSN? ☐ No ☐ Yes	Social Security Number:	Tax ID (only if you do **not** have a SSN):
4. Date of Birth:	5. Client's Preferred Language: ☐ English ☐ Spanish Other:	

6a. Current Gender
☐ Male ☐ Female ☐ Unknown
☐ Transgender: Male to Female
☐ Transgender: Female to Male

6b. Sex at Birth
☐ Male
☐ Female
☐ Unknown

6c. If applicable, are you currently pregnant?
☐ Yes ☐ No Due Date:

7a. Ethnicity (check the one that best describes you)
☐ Hispanic (if Hispanic, please select subgroup)
☐ Mexican, Mexican American, Chicano/a
☐ Puerto Rican
☐ Cuban
☐ Another Hispanic, Latino/a or Spanish origin
☐ Non-Hispanic

7b. Race (check all that apply)
☐ White
☐ Black/African American
☐ Asian (if Asian, please select subgroup)
☐ Asian Indian ☐ Korean
☐ Chinese ☐ Vietnamese
☐ Filipino ☐ Japanese
☐ Other Asian
☐ Native Hawaiian or other Pacific Islander (please select subgroup)
☐ Native Hawaiian ☐ Guamian or Charmorro
☐ Samoan ☐ Other Pacific Islander
☐ Other/Unknown
☐ American Indian/Alaska Native

8. Residential Street Address – (No P.O. Boxes or Rural Routes)	Apartment Number

City	State	Zip Code

*If you wish to have mail sent somewhere **other** than your residential address please provide an alternate mailing address:*

9. Mailing Address - (P.O. Boxes and Rural Routes accepted here)	Apartment Number

City	State	Zip Code

10. Home Phone Number (area code + number) May we leave a voice mail? ☐ Yes ☐ No	Work/Alternate Phone (area code + number) May we leave a voice mail? ☐ Yes ☐ No

If you are unavailable, are there any special instructions as to how we should leave a message for you?

11. **Case Manager (if applicable):**	Case Manager Phone Number:	Agency:

11b. **Alternate contact:** The following individual(s) may speak on my behalf regarding my application and program status. These individuals may be family members or friends.

Name of Person	Relation to You	Phone Number

12. Have you recently been released or are you currently incarcerated in a jail or prison? ☐ Yes ☐ No

Facility Name	Correctional ID #	Release Date

Approximate Length of Incarceration:

IF UNDER 18 : GUARDIAN INFORMATION

If you are under the age of 18 list parent or guardian information. Your parents must complete the Income Section on the next page.

A. Name of Parent or Guardian		B. Name of Other Parent or Guardian (if applicable)	
Social Security Number	Date of Birth	Social Security Number	Date of Birth

MARITAL STATUS

13. What is your current Marital Status: ☐ Single ☐ Widowed ☐ Divorced, Date: ☐ Separated, Date: (explanation required) ☐ Married/Common Law (provide spouse information below)	If you are separated, please explain your current legal situation.
14. Spouse Name:	Spouse SSN:
Spouse Date of Birth:	Is spouse also on program? ☐ Yes ☐ No

HOUSEHOLD INFORMATION

15. Including yourself, how many people live in your home?

Complete the following table for your family. This only includes your legal or common law spouse and children under 18 (including biological, adopted and step-children).

Name	Age and Date of Birth (Birth Date Required for under 18)	Relationship

16. Do you receive HOPWA/Section 8 housing assistance/subsidized housing? ☐ Yes ☐ No
(If yes, include agency verification)

17. Is there anything else you would like to tell us about your living situation that could help clarify your application? For example, if you live with someone who supports you please explain your situation.

INCOME, EMPLOYMENT and BENEFITS

18. How do you support yourself?

☐ I am under 18 (parent must fill out this page) ☐ I'm on disability ☐ I'm a student ☐ I am employed
☐ I don't work, a relative or friend provides room and board
☐ Other (list multiple jobs & employers or any recent job change here):

19. Employment: We may verify your income with other sources such as the Texas Workforce Commission. **Spouse information is required (common law or legally married). Parents of applicants under 18 must be complete this.**

	Applicant or Parent A (if minor)	**Spouse** or Parent B (if minor)	**Required Documentation**
a. Employment Status	☐ Full time ☐ Part time ☐ Unemployed ☐ Temp/seasonal ☐ Self Employed	☐ Full time ☐ Part time ☐ Unemployed ☐ Temp/seasonal ☐ Self Employed	**Are you a student living on financial aid?** • Submit proof of **enrollment and financial aid** from your school's financial aid office. **Do you have NO income?** • The person who supports you must complete the **Supporter Statement (Form A)**. **Are you employed?** • Include 2 current, consecutive **pay stubs**. **If paid weekly**, submit 4 consecutive pay stubs. (For you AND your spouse.) **Do you work but you're paid in cash?** • Have your employer complete the **Income Verification Form (Form B).** **Do you receive benefits?** • A copy of your **benefit award letter** or other official documentation showing the amount received on a regular basis. (For you AND your spouse.)
b. Employer (current or last)			
Job Title (current or last)			
End date (if unemployed)			
20. Income and Benefits: Report **MONTHLY** gross income (the amount received before taxes/deductions). Submit proof of income!			
Wages, salary, commissions, tips, unemployment benefits	$	$	
Social Security Income (SSI or SSDI)	$	$	
Retirement / Pension	$	$	
Other Income (includes financial aid, alimony, investment income)	$	$	Source:

HEALTH INSURANCE

21. Are you currently taking medications for HIV (antiretroviral medications)? ☐ Yes ☐ No
If **yes**, please tell us how you are getting your medications.

22. What types of health care coverage or health insurance do you have? Check all that apply.
<u>If a card is issued copy the front and back of the card.</u>

☐ I do not have health care coverage or health insurance
☐ Private Health Insurance, Employer ☐ Private Health Insurance, Individual
☐ Medicaid (including Star and Star +) ☐ Medicare (Part A, Part B, Part C or Part D)
☐ ACA, "ObamaCare", or Marketplace Plans
☐ Other:

23. Have you previously had any health insurance: ☐ Yes ☐ No If yes, please list name and date coverage ended. **If your insurance terminated in the last 90 days, submit proof of termination.**

Insurance Name:	End Date:
Insurance Name:	End Date:

24. If you currently have health care coverage or health insurance, why are you applying for this program? *(Please check ALL that apply. Submit documentation from the insurance plan verifying your situation.)*

- ☐ I need help paying my medication deductibles, medication copayments, or coinsurance expenses. I have:
  - ☐ Private insurance (complete Copayment Assistance: Insurance on next page)
  - ☐ Medicare (complete Copayment Assistance: Medicare on next page)
- ☐ My insurance does not cover prescription drugs or it doesn't cover one or more HIV meds I need.
- ☐ Coverage will end soon *(specify end date)*:
- ☐ Expenses have or are about to exceed the plan's annual prescription cap.
  Amount of annual prescription cap: $
- ☐ Other limitations on coverage or payment *(specify)*:

ADDITIONAL INFORMATION

25. Is there anything you would like to clarify on this application? Please use this space to provide any additional information that may help THMP process your application. Attach additional pages if needed.

IMPORTANT – THE FOLLOWING CERTIFICATION AND AUTHORIZATION MUST BE SIGNED BY THE APPLICANT:

a. I understand that this application is a legal document. My signature (1) attests that all the information given is true and correct, (2) authorizes the release of my medical information to the Texas HIV Medication Program (THMP) and (3) attests that I do reside in the State of Texas.

b. I understand that it is my responsibility to notify the THMP immediately if my/our income increases; if I/we move from Texas; if my/our residential or mailing address changes; or if my/our marital, household or insurance status changes.

c. I understand that the THMP may request verification of the information I have provided in order to process my application, and also at any time thereafter. I also understand that the processing of my application may be delayed until such requested verification is received.

d. I understand that the THMP may verify information provided on this application with data resources made available to the program for the purpose of eligibility determination.

e. I understand that deliberately omitting or giving false information could cause me to be removed from the THMP, or criminally prosecuted, or both.

f. I understand that the THMP reserves the right to limit enrollment based upon availability of funds.

g. I understand that the THMP is required to recertify my eligibility status per the program rules in order to continue receiving services.

h. I understand that my information will be shared with my HIV service providers and case managers. If I wish to opt out I must list the specific agency name(s) here:

Signature of Applicant *(please print and sign)*	Date
Signature of Parent (if applicant is under 18 years of age) *(please print and sign)*	Date

COPAYMENT ASSISTANCE – Skip page if you do not have:
Medicare part D (State Pharmaceutical Assistance Program)
Or Private Insurance (Texas Insurance Assistance Program)

Applicants with MEDICARE or PRIVATE INSURANCE should fill out this form in addition to the main THMP form. Applicants with insurance or Medicare part D are eligible for assistance. The SPAP provides help with co-pays, coinsurance and gap coverage associated with a Medicare Part D prescription drug plan. The TIAP provides help with co-pays, coinsurance and premiums associated with COBRA plans and private insurance.

First and Last Name	Social Security Number	Date of Birth

DO YOU HAVE MEDICARE? FILL THIS SECTION

Your Medicare Number	Effective Date of Medicare Part A (listed on your Red White & Blue Medicare Card)

Are you enrolled in a Medicare Prescription Drug Plan (Part D)? ☐ No ☐ Yes (if yes, please provide plan information below)

Plan Name:	Effective Date:

Have you applied for the Low Income Subsidy or Extra Help through the Social Security Administration? ☐ No ☐ Yes (please indicate application status below)

Low Income Subsidy/Extra Help Application Status

☐ Approved, 100% Assistance
☐ Approved, partial assistance (attach copy of approval letter)
☐ Denied Assistance (attach a copy of pre-decisional or denial letter)
☐ Awaiting determination, application date:

DO YOU HAVE INSURANCE? FILL THIS SECTION INSTEAD

Are you enrolled in a private insurance plan? ☐ No ☐ Yes (if yes, please provide plan information below)

Plan Name:	Effective Date:	Member ID

Do you have an Affordable Care Act (ACA) Marketplace Plan? ☐ Yes ☐ No Is it: Gold ☐ Silver ☐ Bronze ☐
(If yes, provide information on your approved subsidy or tax credit)

PROVIDE COPY OF FRONT & BACK OF INSURANCE CARD

Is this an Individual, Non-ACA, Off Marketplace Plan? ☐ Yes ☐ No
Is this plan offered through an employer? ☐ Yes ☐ No

If you have COBRA or may be eligible for COBRA, please submit copies of your COBRA paperwork:

Have you already submitted your COBRA paperwork?
☐ No ☐ Yes date submitted:
COBRA Administrator's Phone Number:

COBRA Election/Enrollment Due Date:
COBRA Initial Payment Due Date:
COBRA Account #:

COPAYMENT ASSISTANCE AGREEMENT

1) I understand that it is my responsibility to:
   a) enroll in an insurance plan or enroll in a Medicare Prescription Drug Plan and apply for the Low Income Subsidy,
   b) maintain my enrollment in an insurance plan or a Medicare Prescription Drug Plan, and
   c) pay the monthly prescription drug plan premium directly to the prescription drug plan.
2) I understand that it is my responsibility to notify the Texas THMP SPAP immediately if any of the following happen:
   a) my household income changes, b) my address changes or I move out of the State of Texas, c) my marital status changes, or d) my Medicare benefits are terminated, I lose my insurance coverage or my eligibility for Medicaid or Medicare changes
3) I understand that the THMP reserves the right to limit enrollment based upon availability of funds.
4) I understand that the THMP is required to recertify my eligibility status per program rules in order to continue receiving services.
5) I understand that information may be shared with THMP staff and my insurance plan. I hereby give consent to the THMP to obtain or release my demographic, medical and /or insurance coverage information with other entities as necessary.
6) I agree to participate in a periodic follow up by the THMP Insurance Assistance Program staff to determine the effectiveness of the program.
7) I understand that this is a legal document. My signature (1) attests that all the information given is true and correct, (2) authorizes the release of my medical information to the THMP, including the Texas THMP SPAP, and (3) attests that I do reside in the State of Texas.

Signature of Applicant *(please print and sign)*	Date
Signature of Parent (if applicant is under 18) *(please print and sign)*	Date

FORM A: SUPPORTER STATEMENT

If an applicant has no income or is unable to provide any documentation showing how they manage, this form can be used as documentation. This form must be completed and signed by the person providing support; it **should not** be filled out by the person applying for the program.

I, _____, certify that I currently support
(printed name of supporter)

_____, who resides at the following
(printed name of person you support)

address: _____.
(person you support's street address, city, state, & zip code)

I have supported him/her since _____. My relationship to the applicant
(Date)

is _____.
(examples: parent, spouse, roommate, friend, sister, etc.)

The type of support I provide is (check all that apply):

☐ Room ☐ Food/Clothing ☐ Rent/Mortgage ☐ Utility Bills

☐ Cash Assistance in the amount of $ per month

☐ Other:

Additional explanation (if necessary):

I can be reached at the following number(s) to verify this information:

By signing this form, I affirm that the above information is an accurate statement of assistance being provided to the applicant. I understand that if I deliberately omit or give false information the applicant may be removed from the program and/or criminally prosecuted.

Signature of Supporter *(please print and sign)*	Date

Please note: If there are special circumstances surrounding your household situation that would need to be explained or verified by a social worker, case manager, or public health nurse, please have them provide a detailed support statement on your behalf and attach it to your application when applying for assistance.

FORM B: INCOME VERIFICATION

This form should be used **only when no supporting income documentation is available**. If paystubs are available to the employee copies **must** be submitted. This should be signed by the employer only.

I. Employee Information

Employee Name:

Employee Address:

II. Employer Contact Information

Business Name:

Business Address:

Business Phone Number:

Contact Name: | Contact Phone Number:

III. Employee Income

Type of work performed by the employee:

First Day of Employment: Last Day of Employment (if applicable):

Average number of hours worked per week:

Method of payment *(check one):*
☐ Cash ☐ Personal check ☐ Payroll check ☐ Other (please specify)

Frequency of payment *(check one):*
☐ Weekly ☐ Biweekly ☐ Semi-monthly ☐ Monthly ☐ Daily ☐ Other (please specify)

Gross earnings $ per pay period

Estimated amount of **weekly** tips or commissions: $ *per week*

IV. Employee Health Coverage

Is employer-sponsored health coverage offered? ☐ Yes ☐ No

If yes, is/was this employee enrolled in health coverage? ☐ Yes ☐ No

V. Additional Information

Will there be any changes to this person's employment in the next few months?

VI. Certification

I verify that the above information is true and correct to the best of my knowledge.

Signature of **Employer** *(please print and sign)*	Date

TEXAS HIV MEDICATION PROGRAM
MEDICAL CERTIFICATION FORM

TO BE COMPLETED BY PHYSICIAN **Texas HIV Medication Code (if known)**

The information requested is necessary to determine the patient's eligibility for program-supplied, HIV-related therapy as prescribed by you. All information requested will be kept strictly confidential by the Texas Department of State Health Services; personal identifying info is never released.

PATIENT INFORMATION

Full Name**:** _____

Mailing Address: _____ Apt #: _____

City, State, Zip: _____ Phone #: _____

Date of Birth: _____ Social Security Number: _____

*****NOTICE*** Changes in therapy after initial approval and/or recertification may be faxed to (512) 533-3178.**

I hereby certify that this patient has been diagnosed with HIV infection, and I am reporting the following viral load and CD4 count:

Plasma RNA Viral Load: **copies/ml**	**Test Date:**	**Current CD4 Count:**	**Test Date:**

PRESCRIBED MEDICATIONS FOR OPPORTUNISTIC INFECTIONS:

Please check here if patient is pregnant: ☐

- ☐ **acyclovir,** for acute or chronic herpetic infection *(**NOTE:** not all strengths available due to manufacturer shortages)*, **OR**
- ☐ **valacyclovir**, for acute or chronic herpetic infection
- ☐ **itraconazole**, for diagnosed histoplasmosis or blastomycosis (either caps or OS), **OR** for esophageal candidiasis (OS only)
- ☐ **clarithromycin**, for a current or previous mycobacterium avium complex (MAC) diagnosis, **OR**
- ☐ **azithromycin**, if client failed therapy on (or is intolerant of) clarithromycin
- ☐ **ethambutol**, for a current or previous mycobacterium avium complex (MAC) diagnosis
- ☐ **fluconazole**, for diagnosed cryptococcal meningitis or esophageal candidiasis
- ☐ **valganciclovir** (Valcyte), for diagnosed CMV disease with infection(s) of major organ(s) or organ system(s)
- ☐ **megesterol acetate**, for diagnosed cachexia or anorexia with profound, involuntary, acute weight loss ≥10% of baseline body weight or chronic weight loss ≥20% of baseline body weight
- ☐ **rifabutin** (Mycobutin), for a CD4 cell count ≤ 100
- ☐ **pyrimethamine** (Daraprim), for the treatment and suppression of toxoplasmosis
- ☐ **leucovorin** calcium tablets, used w/Daraprim for treatment/suppression of toxoplasmosis **(please provide RX dosage details)**
- ☐ **pentamidine** or ☐ **SMX/TMP** or ☐ **Dapsone** (choose one, if applicable), for CD4 ≤ 200, or thrush, or previous PCP diagnosis, or unexplained fever>100º for >2 weeks, **OR**
- ☐ **atovaquone** (Mepron), for diagnosed acute, mild to moderate PCP and intolerance to both SMZ-TMP and Dapsone

*****REQUIRED***** Is this patient naïve to antiretroviral therapy? (check one) ☐ Yes ☐ No

PRESCRIBED ANTIRETROVIRAL MEDICATIONS: MONTHLY CLIENT LIMIT OF FOUR ANTIRETROVIRALS (ARVs)

- ☐ **Atripla** (Sustiva/Truvada)*****
- ☐ **Combivir** (AZT/3TC)*****
- ☐ **Complera** (Edurant/Truvada)*****
- ☐ **Epzicom** (Ziagen/3TC)*****
- ☐ **Trizivir** (AZT/Ziagen/3TC)*****
- ☐ **Truvada** (Emtriva/Viread)*****
- ☐ **efavirenz** (Sustiva)
- ☐ **nevirapine** (Viramune XR)
- ☐ **raltegravir** (Isentress)
- ☐ **dolutegravir** (Tivicay)
- ☐ **rilpivirine** (Edurant)
- ☐ **tenofovir** (Viread)
- ☐ **atazanavir** (Reyataz)
- ☐ **darunavir** (Prezista)
- ☐ **indinavir** (Crixivan)
- ☐ **invirase** (Saquinavir)
- ☐ **lopinavir/ritonavir** (Kaletra)
- ☐ **nelfinavir** (Viracept)
- ☐ **ritonavir** (Norvir)
- ☐ **tipranavir** (Aptivus)
- ☐ **fosamprenavir** (Lexiva) – if unboosted dosage, written justification from physician required
- ☐ **cobicistat** (Tybost)
- ☐ **Prezcobix** (Prezista/Tybost)*
- ☐ **Evotaz** (Reyataz/Tybost)*
- ☐ **abacavir sulfate** (Ziagen)
- ☐ **didanosine** (DDI EC)
- ☐ **emtrictabine** (Emtriva)
- ☐ **lamivudine** (3TC)
- ☐ **stavudine** (D4T)
- ☐ **zidovudine** (AZT)
- ☐ **delavirdine** (Rescriptor)
- ☐ **enfuvirtide** (Fuzeon)
- ☐ **Triumeq** (Tivicay/abacavir/3TC)*
- ☐ **elvitegravir** (Vitekta)
- ☐ **Descovy** (Emtriva/Viread TAF)*
- ☐ **etravirine** (Intelence) – For treatment experienced w/viral resistance/toxicity to ARV agents.
- ☐ **maraviroc** (Selzentry) – CCR5 monotropism proof via assay must be attached.
- ☐ **Stribild** (elvitegravir/cobicistat/Emtriva/Viread)*
- ☐ **Odefsey** (Edurant/Emtriva/Viread TAF)*
- ☐ **Genvoya** (Vitekta/Tybost/Emtriva/Viread TAF)*

***Please note:** Combivir, Descovy, Evotaz, Epzicom, Prezcobix & Truvada each count as 2 ARVs; Atripla, Complera, Odefsey, Trizivir & Triumeq each count as 3 ARVs; Stribild and Genvoya each count as 4 ARVs.

PHYSICIAN SIGNATURE**:** _____ TX MD/DO LICENSE #: _____

PRINTED NAME OF PHYSICIAN: _____

OFFICE ADDRESS: _____

TELEPHONE: _____ FAX: _____ DATE: _____